STATE OF WASHINGTON

DEPARTMENT OF LABOR AND INDUSTRIES

Professional Services Fee Schedule

Effective for Dates of Service on or After

August 1, 2003

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KEY TO PROFESSIONAL SERVICES FEE SCHEDULE

KEY TO ANESTHESIA SECTION

Column Title	Column Description	Column Values	Value Definitions
CPT® CODE	2003 CPT® anesthesia code.		2003 CPT® anesthesia code.
ABBREVIATED DESCRIPTION	Abbreviated CPT® code description.		Abbreviated description for reference purposes only. Refer to a 2003 CPT® book for complete code description.
ANES VALUE	Indicates the anesthesia base units, maximum dollar value, or coverage for the anesthesia service.	Number	Anesthesia base units for services paid with the base and time payment method.
		Dollar Value	Fee schedule dollar value for services paid with the maximum fee method.
		By Report	Service paid on a "by report" basis.
		Not Covered	Procedure code is not covered.
PAYMENT METHOD	Indicates the payment method for the anesthesia service.	Base/Time	Service paid with base and time units.
		By Report	Service paid on a "by report" basis.
		Maximum Fee	Service paid based on a maximum dollar value.
		Not Covered	Procedure code is not covered,
BASE SOURCE	Indicates the source of the anesthesia base units.	CMS	Base unit source is the Centers for Medicare and Medicaid Services (CMS).
		ASA	Base unit source is the American Society of Anesthesiologists' Relative Value Guide.
		N/A	Service not paid by base and time unit method

KEY TO EVALUATION & MANAGEMENT THROUGH HCPCS SECTIONS			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
CPT® CODE/ HCPCS CODE	2003 CPT® or HCPCS code		
ABBREVIATED DESCRIPTION	Abbreviated CPT® or HCPCS code description.		Abbreviated description for reference purposes only. Refer to a 2003 CPT® or HCPCS code book for complete code description.
DOLLAR VALUE **NON-FACILITY SETTING**	This column indicates the: • Maximum dollar amount for covered services provided in a non-facility setting, or • Pricing method for the procedure code, or • Coverage status for the procedure code.	Dollar Value	Maximum dollar amount payable for covered services.
		AWP	Code priced based on Average Wholesale Price (AWP) or Average Average Wholesale Price (AAWP).
		Bundled	Bundled code, not separately payable.
		By Report	Service paid on a "by report" basis.
		Contracted	Contracted service. Payable only to department's contracted vendor for State Fund claims. Payable to providers treating Self-Insured injured workers.
		Hosp. Only	Procedure code for hospital outpatient use only.
		Not Covered	Procedure code is not covered.
DOLLAR VALUE **FACILITY SETTING**	This column indicates the: • Maximum dollar amount for covered services provided in a facility setting, or • Pricing method for the procedure code, or • Coverage status for the procedure code.		See "Dollar Value – Non-Faciility Setting" above, for column values and definitions.

KEY TO EVALUATION & MANAGEMENT THROUGH HCPCS SECTIONS (CONTINUED)			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
FOL UP	Follow-up Days for Global Surgery	Number	The number of days following surgery during which charges for normal postoperative care are bundled in the global surgery fee.
PRE OP (-56)	Preoperative Percentage (Modifier –56)	Percent	The percent of the total global surgery dollar value that is allowed when modifier –56 is billed.
INTRA OP (-54)	Intraoperative Percentage (Modifier –54)	Percent	The percent of the total global surgery dollar value that is allowed when modifier -54 is billed.
POST OP (-56)	Postoperative Percentage (Modifier –55)	Percent	The percent of the total global surgery dollar value that is allowed when modifier -55 is billed.
PCTC (26/TC)	Professional and Technical Component (Modifiers –26 and –TC) This field identifies whether **professional and technical component modifers** (-26/-TC) are valid with the procedure code.	0	**Modifiers -26 and -TC are *not valid*.** The procedure is for physician services only; the concept of PC/TC does not apply
		1	**Modifiers -26 and -TC are *valid*.** Diagnostic test or radiology service which has both a professional and technical component.
		2	**Modifiers -26 and -TC are *not valid*.** Stand alone code for the professional component of a diagnostic test. An associated code describes the technical component of the diagnostic test or the global procedure (professional and technical components).
		3	**Modifiers -26 and -TC are *not valid*.** Stand alone code for the technical component of a diagnostic test. An associated code describes the professional component of the diagnostic test or the global procedure (professional and technical components).

KEY TO EVALUATION & MANAGEMENT THROUGH HCPCS SECTIONS (CONTINUED)			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
PCTC (26/TC) ***Continued***	Professional and Technical Component (Modifiers –26 and –TC) This field identifies whether **professional and technical component modifers** (-26/-TC) are valid with the procedure code.	4	**Modifiers -26 and -TC are *not valid*.** Stand alone code for the global procedure for a diagnostic test. Associated codes describe the professional and technical components of the diagnostic test.
		5	**Modifiers -26 and -TC are *not valid*.** Covered service incident to a physician's service when provided by auxiliary personnel employed by and working under the direct supervision of the physician. This service not payable when provided to hospital inpatients or outpatients.
		6	**Modifier -TC is *not valid*; modifier -26 *may be valid*.** Clinical laboratory or other service for which separate payment for interpretations by laboratory physicians or other physicians may be made.
		7	This indicator is not currently in use.
		8	Professional component of a clinical laboratory code; payable *only* if the physician interprets an abnormal smear for a hospital inpatient. **No -TC modifier billing is recognized;** payment for the underlying clinical laboratory test is made to the hospital**.** *Not payable when furnished to hospital outpatients or non-hospital patients.*
		9	**Modifiers -26 and -TC are *not valid*.** Concept of a professional/technical component split does not apply.

KEY TO EVALUATION & MANAGEMENT THROUGH HCPCS SECTIONS (CONTINUED)			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
MSI	Multiple Surgery Indicator (Modifier –51) This field indicates whether multiple surgery payment rules apply to the service.	0	**Modifier -51 is *not valid*.** Payment adjustment rules for multiple surgery do not apply.
		1	This indicator is not currently in use.
		2	**Modifier -51 is *valid*.** Standard multiple surgery payment policy applies (100%, 50%, 50%, 50%, 50%).
		3	**Modifier -51 *may be valid*.** Multiple endoscopic procedures payment policy applies if this service is billed with another endoscopy in the same family.
		4	This indicator is not currently in use.
		9	**Modifier -51 is *not valid*.** Concept of multiple surgery does not apply.
BSI	Bilateral Surgery Indicator (Modifier –50) This field indicates whether the procedure is subject to a payment adjustment for bilateral surgery.	0	**Modifier -50 is *not valid*.** Payment adjustment rule for bilateral surgery does not apply.
		1	**Modifier -50 is *valid*.** Payment adjustment for bilateral procedures (150%) applies to this procedure.
		2	**Modifier -50 is *not valid*.** Payment adjustment for bilateral procedures does not apply. Procedures in this category include services for which the code descriptor specifically states that the procedure is bilateral; procedures that are usually performed as bilateral procedures; or procedures for which the code descriptor indicates the procedures may be performed either unilaterally or bilaterally.
		3	**Modifier -50 is *not valid*.** Payment adjustment for bilateral procedure does not apply. This is a radiology procedure which is not subject to payment rules for bilateral surgeries.
		9	**Modifier -50 is *not valid*.** Concept of bilateral surgery does not apply.

KEY TO EVALUATION & MANAGEMENT THROUGH HCPCS SECTIONS (CONTINUED)			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
ASI	Assistant Surgeon Indicator (Modifiers –80, -81, -82) This field indicates whether or not an assistant surgeon may be paid for the procedure.	0	**Modifiers -80, -81 and -82 are *not valid under normal situations*.** Assistant at surgery is not usually paid for this procedure. Supporting documentation is necessary to establish medical necessity.
		1	**Modifiers -80, -81 and -82 are *not valid.*** Assistant at surgery may not be paid for this procedure.
		2	**Modifiers -80, -81 and -82 are *valid*.** Assistant at surgery may be paid.
		9	**Modifiers -80, -81 and -82 are *not valid*.** Concept does not apply*.*
CSI	Co-surgeons Indicator (Modifier –62) This field indicates whether or not co-surgeons may be paid for the procedure.	0	**Modifier -62 is *not valid*.** Co-surgeons not permitted.
		1	**Modifier -62 is *not valid under normal situations*.** Supporting documentation is required to establish medical necessity of two surgeons.
		2	**Modifier -62 is *valid*.** Co-surgeons may be paid for this procedure. Supporting documentation is not required if two specialty requirement is met.
		9	**Modifier -62 is *not valid* with this procedure.** Concept of co-surgeons does not apply.
TSI	Team Surgeons Indicator (Modifier -66) This field indicates whether or not team surgeons may be paid for the procedure.	0	**Modifier -66 is *not valid*.** Team surgeons not permitted.
		1	**Modifier -66 is *not valid under normal situations*.** Team surgeons may be payable. Supporting documentation is required to establish medical necessity of a team.
		2	**Modifier -66 is *valid.*** Team surgeons permitted.
		9	**Modifier -66 is *not valid*.** Concept of team surgery does not apply.

KEY TO EVALUATION & MANAGEMENT THROUGH HCPCS SECTIONS (CONTINUED)			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
ENDO BASE	Endoscopy Base Code	Code number	This column contains the endoscopic base code for procedure codes that are part of an endoscopy family. The Multiple Surgery Indicator for procedures in an endoscopy family is 3.
FSI	Fee Schedule Indicator This column indicates the payment status for the procedure code.	B	Bundled code, not separately payable.
		C	Contracted service. Payable only to department's contracted vendor for State Fund claims. Payable to providers treating Self-Insured injured workers.
		D	Drug fee based on Average Wholesale Price (AWP) or Average Average Wholesale Price (AAWP).[1]
		F	Flat fee developed by the department
		L	Clinical lab fee
		N	No fee or RVUs available, code paid by report.
		O	For hospital outpatient use only.
		R	RBRVS fee
		X	Non-covered code

1 Maximum fees effective August 1, 2003 are published in the "Average Wholesale Price Fee Schedule" section. These prices are subject to change. Price updates are available from the Provider Hotline at 1-800-848-0811 and on the Medical Aid Rules and Fee Schedules web site

KEY TO LOCAL CODES SECTION			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
Code	Local Code		
Description	Local Code Description		
Maximum Fee		Dollar Value	Maximum dollar amount payable for covered services.
		By Report	No fee or RVUs available, code paid By Report
		Contracted	Contracted service. Payable only to department's contracted vendor for State Fund claims. Payable to providers treating Self-Insured injured workers.
		State Rate	Service paid at state rate for travel or lodging.
Payment Policy Reference			Reference to payment policies related to the local code.

KEY TO AVERAGE WHOLESALE PRICE FEE SCHEDULE			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
CPT®/HCPCS CODE	2003 CPT® or HCPCS code.		2003 CPT® or HCPCS code.
ABBREVIATED DESCRIPTION	Abbreviated CPT® or HCPCS code description.		Abbreviated description for reference purposes only. Refer to a 2003 CPT® or HCPCS book for complete description.
DOLLAR VALUE	Indicates the maximum dollar value, or coverage for the anesthesia service.	Dollar Value	Maximum dollar amount payable for covered services.
FSI	Fee Schedule Indicator	D	Drug fee based on Average Wholesale Price (AWP) or Average Average Wholesale Price (AAWP).
		O	Procedure code for hospital outpatient use only.

KEY TO FEE SCHEDULE FOR CODES FOR HOSPITAL OUTPATIENT USE ONLY			
Column Title	**Column Description**	**Column Values**	**Value Definitions**
HCPCS CODE	2003 HCPCS code.		2003 HCPCS code.
ABBREVIATED DESCRIPTION	Abbreviated HCPCS description.		Abbreviated description for reference purposes only. Refer to a 2003 HCPCS book for complete description.
Hospital Outpatient Payment	This column indicates the: • Maximum dollar amount for covered services, or • Pricing method for the procedure code	Dollar Value	Maximum dollar amount payable for covered services.
		By Report	Service paid on a "by report" basis.
HPI	Hospital Outpatient Payment Indicator	D	Drug fee based on Average Wholesale Price (AWP) or Average Average Wholesale Price (AAWP).
		N	No fee or RVUs available, code paid By Report
FSI	Fee Schedule Indicator	O	Procedure code for hospital outpatient use only.